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RESOURCES FOR PRACTICE

Transgender identity and health care: Implications for psychosocial and physical evaluation

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Abstract

Purpose: The purpose of this article is to educate nurse practitioners (NPs) regarding: (a) the definition and range of transgenderism, (b) social influences on transgender persons, and (c) health care for transgender persons.
Data sources: Data sources include review of the literature in the areas of gender, gender identity, marginalized populations, and gender transition. Personal communication was also utilized.
Conclusions: Transgender persons remain marginalized and may remain closeted and at risk for negative psychosocial consequences. For those that do come out, other issues present, including the navigation of gender transition and psychosocial and physical changes that may be positive and/or negative. Examples of positive effects may include satisfaction of living authentically and decrease in depression. Negative effects may include social discrimination and loss of relationships. To provide holistic care, NPs need to be aware of transgender lives in social context and of their healthcare needs.
Implications for practice: Suggestions for cultivating a supportive healthcare environment include the usage of sensitive language and an appropriate health history and physical examination. Further, to help rectify the knowledge deficit regarding transgender care among healthcare providers, NP educators and preceptors may utilize this article as a resource in their work with students.

Transgender persons (see definitions, Table 1) are collectively increasing their visibility in society as a greater number are coming out and proclaiming their transgender identity. The movies *Normal* (Brokaw & Pilcher, 2003) and *Transamerica* (Macy & Tucker, 2005), as well as the recent media coverage of a female-to-male transsexual giving birth to a daughter (Bone, 2008) are recent examples that help bring transgender lives to the attention of Americans, demonstrating the diversity of human culture and experience.

Healthcare providers strive to provide culturally competent care. However, the majority of healthcare providers lack adequate knowledge to care for their transgender patients (Rondahl, 2009; Sanchez, Sanchez, & Danoff, 2009). Moreover, for many providers, transgenderism remains abstract and "under the radar." Efforts to identify transgender persons are often not in place, and healthcare environments often do not lend themselves to creating a space sufficiently comfortable in which transgender patients feel safe to disclose (Lombardi, 2001). Yet, with or without realizing it, most healthcare providers will, at some point, care for transgender clients (Feldman & Bockting, 2003). Combined, these issues—insufficient cognizance of transgender persons and inadequate knowledge regarding their healthcare needs—make transgender health care often suboptimal and create barriers to healthcare access (Sanchez et al., 2009). Further, overt bias and discrimination in the healthcare setting create additional barriers to healthcare access for transgender persons (Samuel & Zaritsky, 2008). Further still, the lack of formal education that nursing students receive on transgenderism compounds these problems, and portends continued inadequate health care in the future. In a study by Rondahl (2009), only 10% of nursing students were found to have a basic level of knowledge regarding the care of the lesbian, gay, bisexual, and transgender (LGBT) population.

Table 1 Definition of key terms

Natal sex	Identified sex at birth (i.e., male or female); persons born with penises are male; persons born with vaginas are female.
Transgender	Umbrella term for persons who do not conform to gender norms in their identity and/or behavior (Meyerowitz, 2002)
Transsexual	Subset of transgenderism; persons who feel discordance between natal sex and identity (Meyerowitz, 2002)
Gender identity	Self-view as man, woman, neither, both, or in-between (Money & Ehrhardt, 1972)
Gender identity disorder	DSM IV categorization for persons who feel discordance between gender identity and natal sex (American Psychiatric Association, 2000)
MTF	Natal male who identifies as female; transsexual person (Vitale, 2001)
FTM	Natal female who identifies as male; transsexual person (Vitale, 2001)
Cross-gender	Presenting or identifying in a manner that is usually associated with the opposite natal sex (Meyerowitz, 2002)

This lack of knowledge in present and future healthcare providers can lead to preconceptions and inappropriate care (Platzer & James, 2000; Rondahl, 2009). For example, in one case, a female-to-male transgender person was given a rectal examination despite telling the provider that he did not have a prostate (Samuel & Zaritsky, 2008). If suboptimal health care of transgender persons is to be rectified, current and future healthcare providers need to be knowledgeable about, and sensitive to, issues related to transgenderism.

In this article, I move toward increasing providers' knowledge of, and sensitivity to, transgender persons. I first discuss what transgenderism is, including a description of the range of transgender identity. Discussion of transgender lives in social context is next, followed by a review of gender transition. Information regarding obtaining a comprehensive health history and performing an appropriate physical examination of transgender patients follows. Finally, I offer concluding remarks.

Transgender identity

Although the terms are often used interchangeably, there is a distinction between sex and gender. Sex refers to natal sex (i.e., male, female, intersex); gender refers to the "psychological, social, and cultural aspects of maleness and femaleness" (Kessler & McKenna, 1978; p. 7). In general, "male" and "female" have been defined as dichotomous and bipolar sex categories in U.S. culture (Fausto-Sterling, 2000; Lorber, 1993). A quick look at most forms (e.g., health histories) and this becomes apparent. In the majority of cases, a box for either "male" or "female" must be chosen.

Categorization as male or female occurs at birth with the first look at the external genitalia. It is generally expected that individuals will grow up to identify as male or female in accordance with their external sex organs, penis or vagina, and that they will present socially as the corresponding gender—men or women—respectively. In other words, external genitalia determine not only sex, but gender as well, and a congruency between genitalia and gender self-identification is assumed (Kessler & McKenna, 1978).

However, variations in the congruence between sex and gender exist. *Transgenderism* is an umbrella term that refers to appearance, behavior, or identity that does not conform to socially constructed norms for women or men (Meyerowitz, 2002). It is important to note that transgender persons may have sexual partners of any sex or gender. In addition, the range of transgender activity or identity varies widely. For example, transgender persons may choose to dress in cross-gender attire (i.e., not congruent with their natal sex) on occasion or full-time. Further, the gender identity of persons who engage in transgender activity may be congruent with their natal sex. That is, engaging in cross-gender activity does not necessarily indicate cross-gender identification. Cross-gender activity may be pursued for activities of leisure or sexual variety (Meyerowitz, 2002). For example, a natal male who enjoys wearing women's clothing after a frustrating day at work may identify as a man, yet enjoy the relaxation that cross-dressing brings him.

Moreover, transgenderism may indicate gender identity that does not fall neatly into one category. For example, the gender identity of a transgender person may be bi-gender, as exemplified by one individual (Stevens, 2001), who lives on one coast of the United States as a man and on the opposite coast as a woman. Or, a transgender person may self-identify as *genderqueer*. Genderqueer identification can include identification as neither man nor woman, or identification as both man and woman, or, a gender that is considered unidentifiable (Nestle, Howell, & Wilchins, 2002; Wyss, 2004).

Transsexualism, a subset of transgenderism, includes cross-gender identification (Meyerowitz, 2002). Transsexual persons report a feeling of discordance with their natal sex and greater identification with the "opposite" sex (Bower, 2000; Docter & Fleming, 2001). Male-to-female transsexual individuals experience incongruence between their self-identification as women and their natal sex as male; female-to-male transsexual persons experience incongruence between their self-identification

as men and their natal sex as female (Vitale, 2001). Furthermore, there is often discomfort playing the gender role that corresponds with natal sex assignation—that is, the role of man for the male-to-female transsexual person (MTF), and the role of woman for the female-to-male transsexual person (FTM) (Brown & Rounsley, 1996; Schrock, Reid, & Boyd, 2005).

The intensity of discordance between transsexual persons' gender self-identification, assigned gender role, and natal sex varies (Vitale, 2001). Thus, transsexual persons may or may not find it necessary to change characteristics of their physical bodies in order to increase congruency (Schrock et al., 2005). Similarly, among those who do decide to modify their bodies, the degree of transition varies. For example, transsexual persons may pursue physical transition via sex reassignment surgery, breast surgery (i.e., either augmentation or removal), or hormonal supplementation. As well, transsexual persons may elect to live and present as their self-identified gender without choosing hormones or body-modifying surgery. Often, the process of transition is gradual, and the transsexual individual will often experiment with degrees of transition (Aramburu Alegría, 2008). As well, transition decisions are often influenced by familial, health, and financial situations, thus unfolding as these variables evolve. The critical point regarding transsexualism is that there is incongruence between identity and natal sex, that the intensity of this dissonance can vary, and that transsexual individuals may choose varying degrees of transition. As well, it is important to realize that transition is not static. It has been described as a journey that evolves (Aramburu Alegría, 2008).

Some examples of how much transition can vary are illustrated by MTF Joanne (all names are pseudonyms), who takes daily hormones and lives as a woman at home and presents as a man in public (Joanne, personal communication, November 2008). Another example includes FTM Andy, who has had bilateral mastectomy and salpingo-oopherectomy, and lives full-time as a man (Andy, personal communication, April 2009). Yet another example is MTF Nicole, who has had bilateral breast augmentation, takes hormones, has a penis, and lives as a woman full-time (Nicole, personal communication, July 2006). It is important to keep in mind that Joanne's social presentation can evolve if she pursues further transition, and that Nicole may decide to have sex reassignment surgery. Although less likely, it is also possible that any one of these three individuals may choose to resume life that is in accordance with their birth sex, as Alan has. Alan, a natal male, identified and lived as a woman for 10 years, and has now resumed living as a man (Alan, personal communication, July 2009).

Transgenderism in social context

As holistic providers, nurse practitioners (NPs) address patients' psychosocial as well as physical healthcare needs. In so doing, an understanding of the context of peoples' lives facilitates competent and comprehensive care. Thus, it is important to first understand that transgender persons remain marginalized. As such, transgender persons often attempt to conform to social expectations of their assigned gender and conceal the discrepancy that exists between their gender identity and their natal sex (Gagné & Tewksbury, 1998; Vitale, 2001). Hence, MTF persons often marry, raise families, and generally lead lives of conformity to the expectations of their natal sex (Aramburu Alegría, 2008; Tully, 1993; Vitale, 2001). Female-to-male persons often conceal their gender identity by leading their lives as lesbians (Vitale, 2001), making gender variance among FTMs "relatively invisible" in society (World Professional Association for Transgender Health [WPATH], 2001; p. 2. WPATH is formerly known as "Harry Benjamin International Gender Dysphoria Association").

For many transgender persons who have come out, social stigma has led to negative bias ranging from social ridicule to discrimination to violent victimization (Lombardi, Wilchins, Priesing, & Malouf, 2001). Further, these forms of negative bias have been linked to greater rates of unemployment and risk of suicide among transgender persons (Clements-Nolle, Marx, & Katz, 2006; Fitzpatrick, Euton, Jones, & Schmidt, 2005; Kenagy, 2005). Moreover, the media's portrayal of transgenderism exacerbates the social marginalization experienced by transgender persons. Transgender persons are frequently depicted as illicit sex workers, deviant, or freakish. Examples include daytime programs in which transgender persons are often displayed in outlandish feminine attire and audience members are goaded into questions that focus on the transgender persons' deviancy from cultural norms (e.g., Maury Povich show; Povich, 2002). Other examples include evening sitcom shows in which transgender persons are depicted as undesirable persons with whom to become romantically involved (e.g., Ally McBeal show; Kelley, 1997–2002).

Further, these depictions have created an implicit social mindset that remains incognizant of the personal relationships of transgender persons. In other words, the possibility that transgender persons may be partnered romantically with another seems to be outside the contemplative realm of many. Yet, couple relationships that include transgender individuals exist, and these couples report that although their relationships present unique challenges, many aspects are similar to those of

heterosexual, gay, and lesbian couples (Aramburu Alegría, 2008).

In contrast to programming that has been detrimental to the image of transgender persons, more positive exposure has occurred through other media outlets (e.g., Oprah Winfrey show; Winfrey, 2007) in which transgender persons have been allowed opportunity to speak openly and educate the public on the nature of transgenderism. Indeed, transgender persons and supportive others have been eager to assume a role of social activism in educating the public about transgenderism (Aramburu Alegría, 2008).

Gender transition

Transgender persons experience challenges whether or not they choose to disclose their transgender identity. Potential consequences of disclosure include risk of violence or loss of relationships or employment. Given these possibilities, self-disclosure does not always occur, and transgender persons often remain closeted and at risk for psychosocial consequences, including depression, anger, anxiety, and suicidal ideation (Fitzpatrick et al., 2005; Vitale, 2001).

However, for those that do come out, challenges also persist. For example, anxiety and depression related to transition issues may present. In the public setting, decisions regarding transition in the work place must be made, and socially appropriate behavior in the new gender must be learned. Further, guilt associated with disrupting personal relationships and other relational challenges arise and must be addressed when the disclosure occurs after relationships have been established. On the other hand, many transgender persons report personal and relational improvements that result from living authentically in their gender. Examples include the emergence of a more confident self-image, decrease in depression, and improved communication in relationships (Aramburu Alegría, 2008).

Despite the potential negative consequences that may challenge those who do come out, the potential positive effects of living authentically motivate many transgender persons to disclose and begin transition. WPATH describes the standard of care for transition. These standards include: (a) evaluation by a mental health professional, (b) hormonal therapy, and (c) year of real-life experience, or living in the desired gender for 1 year prior to sex reassignment surgery (SRS). It is important to recall that not all transgender persons elect, or are able, to have SRS. The range of transition in transgender persons can vary from minimal (e.g., clothing only) to complete anatomical reconstruction (e.g., SRS and breast surgery). Regardless of the transition extent, implementation and adherence to the WPATH standards facilitates comprehensive care. This care may best be accomplished through an interdisciplinary network that includes clinicians in the areas of primary care, endocrinology, mental health, and surgery (WPATH, 2001).

Health history and physical examination

Given the potential negative consequences of disclosure, transgender persons may be reluctant to express their transgenderism to healthcare providers. Barriers to disclosure in the healthcare setting can include embarrassment, fear of discrimination or bias, or anxiety that family members will be informed. These barriers limit providers' ability to provide psychosocial evaluation—critical in the evaluation of transgender patients, given the prevalence of depression, anxiety, and suicide among transgender persons (Clements-Nolle et al., 2006; Fitzpatrick et al., 2005). Indeed, caring for clients with conditions such as sexual disorders, depression, anxiety, substance abuse, and personality disorders on occasion uncovers transgenderism (WPATH, 2001).

Purposeful effort needs to be made toward creating a receptive environment. An environment that is perceived as welcoming and supportive may allow more open communication. The following preface and questions may be used to reflect support and facilitate psychosocial evaluation:

> As part of a full health evaluation, I'll be asking questions regarding gender and sexuality, as they can impact mental and physical health. People are sometimes hesitant to be open about gender and sexuality, but please be assured that your responses are confidential.

1. Are you experiencing any challenges, concerns, or anxieties related to your sexuality?
2. Are you comfortable with your sexuality and your sexual relationships?
3. Are you experiencing any challenges, concerns, or anxieties related to your gender identity? Are you comfortable with your gender identity and how you present your gender? Related to your gender, how do you identify?
4. Are your sexuality and/or gender identity presenting any challenges, concerns, or anxieties for your relationships (e.g., family, friends, work, etc.)?
5. Are you experiencing any sadness, depression, anxiety, thoughts of harming yourself, or suicide?
6. Have you or are you experiencing any violence or discrimination in your personal or occupational life?

When patients report transgender activity, identity, or other nonconventional forms of gender, an initial

Table 2 Additional resources

Organizations

1. World Professional Association for Transgender Health (WPATH)
   Bean Robinson, PhD (USA)
   Executive Director
   Jeffrey Whitman (USA)
   Executive Administrator
   E-mail: wpath@wpath.org
   1300 South Second Street, Suite 180
   Minneapolis, MN 55454
   http://www.wpath.org/index.cfm
2. International Foundation for Gender Education (IFGE)
   P.O. Box 540229
   Waltham, MA 02454
   Tel: (781) 899–2212
   E-mail: info@ifge.org
   http://www.ifge.org/
   (Includes state-specific resources)

Recommended reading

1. Brown, M., and Rounsley, C. (1996). *True selves: Understanding transsexualism*. San Francisco: Jossey-Bass Publisher (A resource for transgender persons, their families, and other loved ones).
2. Boylan, J. F. (2004). *She's not there: A life in two genders*. New York: Broadway (A resource for partners/spouses of transgender persons).

supportive approach is to let patients know that they are not alone in their activity or identity, and that good sources of information are available. Resources and recommended reading for providers, patients, and their families are provided in Table 2.

On rare occasion, patients may request that information regarding their transgender identity not be documented in their medical record. The medical record helps ensure continuity of comprehensive care, and should be as complete as possible. Discussing confidentiality concerns with patients, educating them regarding the federal law on medical privacy, the Health Insurance Portability and Accountability Act Privacy Rule (HIPAA; United States Department of Health and Human Services, 2003), and informing them that they can restrict others from access to their medical record may help alleviate anxiety regarding unintended disclosure of transgender identity.

Addressing transgender persons in a gender-appropriate manner can further help cultivate a supportive environment. In general, MTFs should be addressed as women; FTMs should be addressed as men. However, exceptions always exist, and it may be necessary to ask patients how they would like to be addressed. Similarly, when discussing health issues related to anatomy, it can be helpful to use phrases such as, "persons with vaginas," or "persons with penises," rather than "females" or "males," respectively (Samuel & Zaritsky, 2008). Many transgender persons find sex-oriented labels distressing. Using phrases such as those mentioned can further facilitate a supportive environment. Key points for providing a supportive environment are presented in Table 3.

Table 3 Key points: Measures to cultivate supportive environment

Ask transgender persons how they prefer to be addressed. Do not assume that a cross-gender appearance indicates that the individual prefers a specifically gendered name.

Be cognizant of pronoun usage.

Be mindful of language that labels (e.g., the phrase "persons with ovaries" is preferable to the term "females" or "women."

Psychosocial inquiry should include history of substance abuse, including tobacco, alcohol, pain medications, street drugs; history of employment, including periods of unemployment; and depression, anxiety, or anger. Risk of sexually transmitted infections should be ascertained via questioning regarding sexual history, just as these questions would be asked of any patient. Providers should not assume that FTMs who have a vagina do not engage in penetrative sex. Hence, the health assessment should also include information about the possibility of pregnancy (Feldman & Bockting, 2003).

The health history should include questions regarding hormones and other feminizing or masculinizing agents. Generally, hormonal and other feminizing/masculinizing regimens are prescribed and monitored by endocrinology specialists, and discussion of the management of specific regimens is beyond the scope of this article. However, as primary care providers, NPs need to be aware of the varying hormonal and feminizing/masculinizing regimens their transgender patients may be prescribed. For the MTF, this includes estrogen formulations, progesterone, and/or androgen blockers; for the FTM, androgens (i.e., testosterone) may be prescribed. The regimens can vary from individual to individual (for a review, see Moore, Wisniewski, & Dobs, 2003) and can vary for one individual as well, dependent on transition status. Common feminizing and masculinizing agents prescribed for transgender persons, their effects, and suggested laboratory workup (Lawrence, 2004; Moore et al., 2003) are listed in Table 4.

Evaluation regarding the suitability of feminizing/masculinizing treatment should include the evaluation of associated risk/benefit within the context of patients' overall health and co-morbidities. For example, the risk of thrombosis development, liver disease, cancer, and lipid disorders from these medications should be evaluated in relation to the transgender persons' general health, just as in nontransgender persons (Gooren, 2005). If unacceptable potential risk is identified, consultation with the patient's sub-specialty provider is strongly recommended.

Table 4 Feminizing/masculinizing agents, effects, and suggested laboratory/imaging studies

Male-to-female:	Feminizing effects:	Laboratory/imaging studies:
Estrogens: Oral estradiol, 6–8 mg PO or sublingual daily Oral conjugated estrogens, 5 mg PO daily Transdermal estradiol, two 0.1-mg patches changed twice weekly Progesterone: Progestin: 5–10 mg daily for 10 days of the month Antiandrogen: Spirinolactone, 200–400 mg PO daily Finasteride, 6 mg PO daily	Gynecomastia Softer skin Reduced testicular volume Decreased erectile function Decreased hair growth Decreased libido Enlargement of nipples Testosterone to female levels	Free testosterone Fasting chemistry panel Fasting lipid profile Complete blood count Estradiol level if feminization appears to be inadequate PSA Pap smear (if vagina is present) Mammogram (if feminization present)
Female-to-male:	**Masculinizing effects:**	**Laboratory/imaging studies:**
Androgens: Testosterone enanthate, 75–100 mg IM weekly, or 150–200 mg IM q 2 weeks Transdermal testosterone patch, 5–7.5 mg, changed daily Transdermal testosterone gel, 5–10 mg, applied daily	Deepening of voice Increased aggression Increased libido Cessation of menses Hirsutism Clitoral growth Breast atrophy Redistribution of fat Laryngeal prominence Testosterone to male levels	Fasting lipid profile Liver function tests Complete blood count Pap smear (if vagina is present) Mammogram (if breast tissue present)

IM, intramuscular; PO, by mouth; q, every; PSA, prostate-specific antigen; Pap, Papanicolau.

In addition to the physical effects of feminizing and masculinizing agents, psychological effects and personality changes may also be present, and apparent to the transgender individual and family members. These changes may be perceived as positive and/or negative. For example, transgender persons may feel joy at the physical changes that accompany hormonal regimens, yet also experience labile moods. Thus, inquiry should be made regarding any psychosocial ramifications that have resulted from hormonal therapy. These questions can include, for example, "Often taking hormones affects not only the body, but the mind and personality as well, and our loved ones often notice these changes. Are you experiencing any changes that you'd like to discuss?" Responses to questions such as this may warrant further counseling or mental health referral for patients and their families.

The health history should also include inquiry into surgical history. Specifically, in relation to transition, inquiry should be made into breast surgery in the MTF, and breast surgery and salpingo-oopherectomy and hysterectomy in the FTM (Dutton, Koenig, & Fennie, 2008; Feldman & Bockting, 2003). The prostate remains in MTF persons, and inquiry should be made regarding symptoms of prostate health (e.g., urinary hesitancy).

Physical and laboratory examination of transgender persons should be based on current anatomy, medications, and comorbidities, rather than birth sex or gender presented. Physical and laboratory examination of the MTF who has had sex reassignment surgery should include pelvic examination with Papanicolau (Pap) smear, prostate exam, prostate specific antigen (PSA), and mammograms. Examination of the FTM with a vagina should include pelvic examination with Pap smear, clinical breast exam, and if breast tissue is present, mammogram (Feldman & Bockting, 2003). Key points of health history and physical examination of the transgender patient are presented in Table 5.

Summary and conclusion

Transgender persons often experience stigma, marginalization, discrimination, and violence in society, and anxiety over negative consequences of disclosure keep many transgender persons closeted (Aramburu Alegría, 2008; Vitale, 2001). In addition, barriers to accessing health care and/or disclosing to healthcare providers a transgender identity include fear of ridicule, suboptimal health care, and discrimination. Further, for transgender persons who do come out, health care is often inadequate as providers may not have adequate knowledge regarding care of the transgender patient. Consequently, mental and healthcare needs are not met (Platzer & James, 2000; Rondahl, 2009; Sanchez et al., 2009).

Table 5 Key points: Health history, physical exam, and suggested questions

Sexuality	"Do you have any concerns or questions regarding your sexuality? Are you comfortable with your sexuality? Does your sexuality present any challenges for yourself or for your relationships?"
Identity	"Do you have any concerns or questions regarding your gender identity? Are you comfortable with your presentation of gender? Does your gender identity create any challenges for yourself or for your relationships?"
Transition: Surgical history, hormones, utilization of other providers	"Have you had any pelvic surgery? Have you had breast surgery? Have you had genital surgery? Have you had any other surgical procedures to alter your body/appearance? Do you have any other providers that are assisting you with these procedures or transition? Do you take hormones or other substances that may have feminizing/masculinizing effects?"
Psychosocial: Mental health, relationships, employment, substance abuse, concerns of discrimination, violence, other forms of bias	Screen for depression and anxiety. "Are there any other questions or concerns related to relationships that we haven't discussed? Do you have any concerns related to employment? Have you experienced any discrimination, bodily harm, or threats of bodily harm? Do you think about suicide or harming yourself?"
Physical exam: Consider current anatomy, medications, comorbidities	Prostate exam and PSA in MTF, pelvic exam in MTF, clinical breast exam in MTF, pelvic and breast exam in FTM.

PSA, prostate-specific antigen; MTF, male-to-female; FTM, female-to-male.

Sensitive questioning and appropriate use of language help provide a supportive environment for care of the transgender patient. Screening and physical exam should be based on current anatomy, medications, and comorbidities. An interdisciplinary network of healthcare providers that includes primary care, endocrinology, mental health, and if needed, surgery, can best provide comprehensive care that is in accordance with WPATH guidelines.

Lastly, providing thorough care for the transgender population begins with awareness and education for current and future healthcare providers. Education regarding the care of transgender patients should be incorporated into all nursing education. To help rectify the knowledge deficit regarding transgender care among healthcare providers, NP educators and preceptors may utilize the information presented in this article as a resource in their work with students.

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